

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1911	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2011
NAME OF PROVIDER OR SUPPLIER DONELSON PLACE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 2733 MCCAMPBELL ROAD NASHVILLE, TN 37214			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments During the annual Licensure survey and complaint investigation numbers 27046, 27370, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 001			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Administrator

(X6) DATE

4-8-11